

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>011840</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/07/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SUMMIT PLACE WEST</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>55 N MISSION DR INDIANAPOLIS, IN 46214</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaints IN00159568 and IN00150739.</p> <p>Complaint IN00159568 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00150739 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: April 7, 2015</p> <p>Facility number: 011840 Provider Number: 011840 Aim Number: N/A</p> <p>Census bed type: Residential: 50 Total: 50</p> <p>Census by payor type: Medicaid: 27 Other: 23 Total: 50</p> <p>Sample: 5</p> <p>Summit Place West was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00159568 and IN00150739.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE